

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHAB CONFERENCE

Submitted by: ☐ Claimant ☐ Employer / Insurer ☐ Supplier

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	Phone Number	County of Injury	EMPLOYER	Name	
Address			Address		Phone Number
City	State	Zip Code	City	State	Zip Code
Employee E-mail			Employer E-mail		
REHAB SUPPLIER	Name		INSURER / SELF-INSURER	Name	
Address		Phone Number	CLAIMS OFFICE	Name	
		Registration Number	Address		Phone Number
City	State	Zip Code	City	State	Zip Code
Supplier E-mail			Claims E-mail		SBWC ID# (five digit no)
ATTORNEY FOR EMPLOYEE / CLAIMANT	Name		ATTORNEY FOR EMPLOYER / INSURER	Name	
Address		Phone Number	Address		Phone Number
City	State	Zip Code	City	State	Zip Code
GA Bar number			GA Bar number		
Attorney E-mail			Attorney E-mail		

B. ISSUES:

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C. CERTIFICATE OF SERVICE

<input type="checkbox"/> I certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, GA 30303-1299	
Print Name Here	Telephone Number
Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwg.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).